DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

June 8, 2023

Administrator
ADARA HOME HEALTH INC
25 1ST AVENUE NE STE 100
BUFFALO, MN 55313

RE: Event ID: 5F7C5-H2

Dear Administrator:

On June 1, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance with federal regulations and state licensing statutes.

Feel free to contact me with any questions related to this letter.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248056 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/13/2023 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ADARA HOME HEALTH INC | 25 1ST AVENUE NE STE 100 , BUFFALO, Minnesota, 55313 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| G0000 | INITIAL COMMENTS<br><br>On 4/11/23 – 4/13/23, a complaint survey was conducted. This resulted in a partially extended survey at Adara Home Health. The agency was found to have not met the requirements at 42 CFR. Part 484 for Home Health Agencies.<br><br>The cumulative effects of these findings resulted in the Home Health Agency's inability to ensure provision of quality of care.<br><br>H80561264C/94355 was unsubstantiated with no deficiencies issued.<br><br>H80561266C/95974 was substantiated with deficiency issued at G478.<br><br>H80561265C/95003 and H80569977C/97183 were substantiated with deficiency cited at G536.<br><br>The Condition of Participation 42 CFR 484.50 Patient Rights at G430 and 42 CFR 484.55 Comprehensive Assessment of Patients at G536 was found not met. | G0000 | | |
| G0478 | Investigate complaints made by patient<br><br>CFR(s): 484.50(e)(1)(i)<br><br>(i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics:<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on interviews and document review, the facility failed to thoroughly investigate a medication error for 1 of 1 client (P3) who reported her iron medication was set up daily instead of every other day as ordered.<br><br>P3's Home Health Certification and Plan of Care (POC) dated 1/17/23 to 3/17/23, indicated diagnoses of anemia, gastric ulcer, unspecified as acute or chronic without hemorrhage or perforation, irritable bowel | G0478 | 1. P3's concern/compliant investigation was re-evaluated by Area Manager to ensure a complete investigation is conducted.<br>2. Agency will perform a focused audit on concerns/complaints and potential medication error investigations that were done in the month of March to ensure those investigations were completed appropriately.<br>3. Agency will re-train Area Managers and Clinical Supervisors on the investigation process of concerns/complaints, potential medication errors and Vulnerable Adults/Children to assure compliance with company policy. Agency created an e-mail group of Parent clinical leadership team members to expedite immediate oversight & review of concerns/complaints and potential medication error occurrences. Agency will review/revise Medication Errors and Complaint policies to incorporate any change necessary.<br>4. Agency will perform a follow-up audit 1 month after training completed on concerns/complaints and potential medication error occurrences to ensure an investigation was completed according to policy. Monitoring frequency will be determined based on results. All occurrences and complaints will continue to be reviewed by the Parent Director of Quality Management to ensure thorough investigation/resolution.<br>5. Person Responsible: Rachel Eastwood, VP of Nursing<br>6. Completion date: Training and focused audit will be completed by May 31st, 2023, follow-up audit by June 30th,2023. | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | ADMINISTRATOR | 5/14/2023 |

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| G0478 | Continued from page 1<br>syndrome without diarrhea and gastroesophageal reflux disease. P1's frequency of visits was skilled nursing visits (SNV) once every other week to review medication profile and reconcile medications as needed and may fill medi-planner per current medication orders/profile. P3's POC indicated she received Ferrous Gluconate (iron) 324 milligrams (mg) tablet every other day,<br><br>A complaint made to the facility for P3 on 2/08/23, from P3's Care Coordinator (CC) indicated there were some concerns her registered nurse (RN) was consistently mixing her medication and have not ordered medications on time causing [P3] not to receive certain medications for weeks. In addition, the complaint indicated the patient stated she had current eye surgery and was no longer able to check the medications that were set up by the RN. The CC further requested to increase her SNV visits to weekly.<br><br>The facility investigation indicated they spoke to licensed practical nurse (LPN)-G, who stated P3 told her that iron was set up daily and it was supposed to be every other day. LPN-G stated the client had received 90 days (45 tablets) about a month and a half ago and that it was gone. In addition, LPN-G stated P3, informed her the PCA had pulled the iron out, but some were taken, could not estimate how many. The investigation then indicated an interview with LPN-H who allegedly performed the preparation error and she had specifically remembered setting up the medications every other day which was documented in the medication setup note. LPN-H also indicated she also practices having her clients look at the medication set up prior to departure and recalls [P3] stating they looked good. The report indicated they did receive orders to increase her visits to weekly.<br><br>During interview on 4/12/23, at 4:50 p.m. with the area director (AD) at the Blaine branch office stated LPN-G went out to P3's home after the complaint was made and since the PCA took the medications out there was no way to know if there was an error or not, it was just an allegation and there was no way to prove it. In addition, since she had the correct number of pills left, they felt it really could not have been an error. The AD did state they never did contact the pharmacy to verify the medication amount, nor did they call the PCA to see if she could verify seeing the iron in the medication set up as daily. | G0478 | | |

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| G0478 | Continued from page 2<br><br>A facility policy titled Client Incident, Accident, Injury, or Unusual Occurrence dated 4/17/18 indicated the supervisor should review the Unusual Occurrence Report and determine the factors which contributed to the occurrence and complete the required documentation. The completed Unusual Occurrence Report should be submitted to the Branch General Manager for review and investigation if necessary. | G0478 | | |
| G0510 | Comprehensive Assessment of Patients<br><br>CFR(s): 484.55<br><br>Condition of participation: Comprehensive assessment of patients.<br><br>Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment.<br><br>This CONDITION is NOT MET as evidenced by:<br><br>Based on the number and/or severity of the deficiency cited the Condition of Participation 42 CFR 484.55 Comprehensive Assessment of Patients at G536 was found not met. The agency failed to ensure accurate medication set-up for 2 of 2 patients (P1 and P2) reviewed when an antipsychotic medication, Abilify, for P1 was not ordered and set up as prescribed. P1 went without Abilify for approximately 28 days and was hospitalized and nursing staff entered an order for Montelukast (prevent symptoms of asthma) 10 mg daily without receiving a verbal physician order. P2's medication for neuropathy and iron were not set-up as prescribed resulting in addition dosing and skilled nursing visits for patient monitoring.<br><br>Refer to G536 - Based on interview and document review the agency failed to ensure accurate medication set-up for 2 of 2 patients (P1 and P2) reviewed when an antipsychotic medication, Abilify, for P1 was not ordered and set up as prescribed. P1 went without Abilify for approximately 28 days and was hospitalized and nursing staff entered an order for Montelukast (prevent symptoms of asthma) 10 mg daily without receiving a verbal physician order. P2's medication for neuropathy and iron were not set-up as prescribed resulting in addition dosing and skilled nursing visits for patient monitoring. | G0510 | Refer to G0536 | |

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| G0510 G0536 | A review of all current medications<br><br>CFR(s): 484.55(c)(5)<br><br>A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on interview and document review the agency failed to ensure accurate medication set-up for 2 of 2 patients (P1 and P2) reviewed when an antipsychotic medication, Abilify, for P1 was not ordered and set up as prescribed. P1 went without Abilify for approximately 28 days and was hospitalized and nursing staff entered an order for Montelukast (prevent symptoms of asthma) 10 mg daily without receiving a verbal physician order. P2's medication for neuropathy and iron were not set-up as prescribed resulting in addition dosing and skilled nursing visits for patient monitoring.<br><br>P1's Home Health Updated Plan of Care Report (POC), dated for the certification period 3/13/23 through 5/11/23, indicated P1 had bipolar and anxiety disorders. The POC further indicated P1 received skilled nursing visits (SNV) one time a week times five weeks to observe and assess P1 with generalized depression and to assess the need for medication changes and the potential for the need for referral to provide counseling and assistance with managing depression. The POC further indicated P1 would receive a skilled assessment to evaluate the patient for maladaptive, aggressive, noncompliant, self-harming, and/or abusive behaviors. Assess medication/treatment compliance, the need for medication changes, and the potential need for referral to a provider for counseling/assistance with managing behaviors. Provide skilled teaching to promote personal safety, reduce maladaptive behaviors, improve daily health practices, and report significant concerns in behaviors to physician and nurse practitioner (NP) for interventions dated updated 4/04/23. P1's POC further indicated she received Abilify 20 milligrams (mg) for major depression daily.<br><br>A Facility Reported Incident dated 3/31/23, indicated on 3/31/23, at 12:00 p.m. the home care agency received a phone call from the hospital pharmacy stating [P1] | G0510 G0536 | Agency is submitting IDR of condition level deficiency CFR(s): 484.55 related to the following findings:<br>•P1's verbal order for resumption of care on 2/7/23 was signed by the provider on 2/13/23 without the Abilify medication listed on the medication list which contributed significantly to the length of time P1 missed her Abilify medication. This is stated in the SoD. Provider also signed on 3/17/23 the 3/13-5/11/23 on Plan of Care recertification without the Abilify on the medication list.<br>•Additional information was received by the Agency from LPN-C regarding P1's Montelukast verbal order stating she used the prescription bottle in the client's home to enter the verbal order on 3/22/23 for this medication. The provider signed this verbal order on 3/29/23.<br>•RNCM-A stated he communicated to the PA's nurse on 3/31/23 about the concern of P1 not receiving her Abilify when he reconciled the medications with the provider.<br>1. Once the concern for P1 and P2 was identified agency took immediate action to ensure P1 and P2's immediate safety need was met and internal investigations were completed. Corrective action, re-education, and competency evaluation was implemented by the location with the nurse(s) involved, unless the nurse(s) resigned before the action could be completed.<br>2. Agency will coordinate a focused audit in quarter 2 to compare medication set-up documentation with the medication profile to ensure medications are set up as ordered by the provider. Ongoing monitoring and additional training will be dependent on audit findings. Audit depending on results to ensure following correct process.<br>3. Mendota Heights nurses have all completed a Lippincott Medication Management course (all RN's also completed the Medication Reconciliation course). All nurses will be receiving individual competency evaluation by their clinical supervisor on medication set-up practices. All office locations will be receiving re-training on Medication Management in Home Health led by the Parent clinical leadership team which will include: monitoring, documenting, reporting potential adverse effects of high risk medications, how to document a medication set up, when to notify the provider of missed doses or medication concerns, and reviewing/reconciling medication orders. | |

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| G0536 | Continued from page 4<br>was admitted to the hospital for symptoms of hypomania, the pharmacy also advised they were worried [P1] was not receiving the correct medications set up in the home by the agency. After coordinating with the primary care provider, in reconciling medications not set up for the client of Abilify (an antipsychotic medication) from 2/06/23 to 3/10/23 and 3/24/23 through 3/31/23.<br><br>The facility Investigation addendum from 3/31/23 indicated there was an additional medication error that occurred with P1. Licensed Practical Nurse (LPN)-C stated she entered an order for Montelukast (prevent symptoms of asthma) 10 mg daily on 3/22/23, without receiving a verbal order. LPN-C stated she entered the order because P1 stated she should be taking it.<br><br>During interview on 4/13/23, at 10:37 a.m. P1's registered case manager (RNCM)-A stated he took over P1's case on 4/01/23, although RNCM-A had known her previously through the agency. RNCM-A stated he received a phone call on 3/31/23, from P1's hospital pharmacist questioning what medications P1 was receiving and wanted to go over her medication list. RNCM-A stated he then notice P1 had missed her Abilify medication due RN-D had accidentally discontinued it from the medication list during the resumption of care visit on 2/7/23. The provider signed the resumption of care order on 2/13/23 that did not include the Abilify listed as part of the medication regimen, therefore it was not reflected within the medication profile following the 2/7/23 visit. In addition, RNCM-A stated RNCM-B copied and pasted the previous medication list which had the Abilify listed and did set up the [P1]'s Abilify through 2/21/23. LPN-C performed a visit on 2/21/23 and followed the medication profile to set up the medications which did not have Abilify listed, therefore did not fill the Abilify medication from 2/21/23 to 3/10/23. On 3/10/23, RNCM-B set up the Abilify medication from 3/10/23 through 3/24/23 after copying and pasting a previous medication list which reflected the medication prior to the resumption of care visit. On 3/22/23, LPN-C did not set up Abilify from 3/22/23 through 3/31/23, due to the medication profile not listing the medication as it was discontinued following the resumption of care visit.<br><br>During interview on 4/13/23, at 11:00 a.m. P1's physician assistant (PA), and registered nurse (RN)-G stated P1 received a call from RNCM-A informing the PA, P1 was becoming more manic and had a fall on 4/11/23 and had lost her leg strength and had two other falls. | G0536 | Education methods will include Parent leadership lead training, staff meetings, and electronic communications.<br>4. Agency will perform a follow-up audit 1 month post agency training to occur in June 2023.Continued audits will be performed based on the results. Expected compliance is 100%.<br>5. Person responsible: Rachel Eastwood, VP of Nursing<br>6. Completion date: Training and focused audit by May 31, 2023, follow-up audit by June 30th, 2023. | |

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| G0536 | Continued from page 5<br>RN-G stated she was never informed P1 missed receiving her Abilify medication and that would have been important to know, especially since P1 went to the emergency department again this week. In addition, RN-G stated she spoke with the (PA) who stated P1's hospitalization on 3/31/23, was due to missing her Abilify medication.<br><br>P1's Hospital Discharge Summary dated 4/03/23 indicated P1's discharge diagnoses were mixed bipolar disorder related to malingering (falsification or profound exaggeration of illness), the discharge summary further indicated P1 had symptoms of thrashing her apartment, paranoia, anxiety, and impulsivity upon admission. The discharge summary further indicated that P1 is to continue her Abilify 20 mg in the evening.<br><br>During interview on 4/13/23, at 11:30 a.m. director of quality improvement (DOQI) stated RN-D and LPN-C had received coaching on their medication error and both are assigned to complete medication procedure in Lippincott by 4/15/23 and attend medication training on 4/20/23.<br><br>P2's POC dated 12/24/22 through 02/21/23, indicated P2 had idiopathic chronic gout, superficial frostbite, cellulitis of the left lower limb, and acute embolism of the right femoral vein. In addition, the POC indicated P2 received skilled nursing one time a week to review the medication profile and reconcile medications as needed. P2's POC further indicated P2 received Gabapentin (for neuropathy) 100 mg capsules, 200 mg at 8:00 a.m. and 100 mg at 5:00 p.m. and Ferosul (iron) 325 mg take one tablet daily.<br><br>A Facility Reported Incident dated 12/28/22, at 12:37 p.m. indicated licensed practical nurse (LPN)-A completed a skilled nursing visit on 12/28/22, and noticed medications set up by registered nurse (RN)-F, had errors which included two iron pills that should have been only one pill, in addition, the P2 had orders for gabapentin 100 mg three times daily (for a total dose of 300 mg daily), and the medication set up was 300 mg in the morning, and 300 mg the evening in addition to some evenings it also had 400 mg set up in P2's pill box.<br><br>The agency investigation undated, indicated they informed P2’s physician of the medication error and | G0536 | | |

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| G0536 | Continued from page 6<br>received an order for P2 to be seen for SNV daily for seven days for close assessment of the client's condition and monitoring for any signs or symptoms of side effects or adverse reactions and no further action was needed but an ongoing assessment of the client's status and reporting any side effects and adverse reactions to the physician immediately. In addition, the investigation indicated P2's Gabapentin order was changed to 200 mg in the morning and 100 mg in the evening since the dose flip machine only allowed for P2's medication to be set up twice daily.<br><br>During interview on 4/11/23, at 10:45 a.m. the director of quality improvement (DQI) stated registered nurse (RN)-F made the medication errors with P2's medication set up and while they were completing their investigation, they were unable to contact RN-F because she was on vacation. DQI then stated when they tried to have her come in and talk with her, she resigned and dropped her supplies of at another employee's house, so they never were able to interview her.<br><br>Medication Error Policy revised 5/10/21, indicated a medication error is any error significant or not significant, that includes all errors in wrong medication, wrong time, wrong dose, extra dose, wrong route of administration, omission of ordered dose, or length of infusion whether caused by an employee or the client. The policy also identified a significant medication error as any error that requires or results in any of the following: discontinuing a medication or modifying a dose, hospitalization, disability, treatment with a prescribed medication, cognitive deterioration or impairment, life-threatening situation, death, or congenital anomalies. Once a medication error is noted, the employee is to notify the Case Manager and complete an Unusual Occurrence Report. The Branch General Manager or Clinical Manager is informed of the occurrence by the Case Manager and notify the physician and intervene as needed. | G0536 | | |

Protecting, Maintaining and Improving the Health of All Minnesotans

**Revised to replace the letter dated May 4, 2023, to reflect the correct Condition of Participation out of compliance.**

Electronically Delivered Via Email

May 17, 2023

Administrator
ADARA HOME HEALTH INC
25 1ST AVENUE NE STE 100
BUFFALO, MN 55313

RE: Event ID: 5F7C5-H1

Dear Administrator:

An partial extended survey was completed at your agency on April 13, 2023 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division noted one or more deficiencies and found that your agency was not in substantial compliance with the participation requirements. The findings from this survey are documented on the electronically delivered form CMS 2567.

At the time of this survey, it was determined that the following Condition(s) of Participation were found not met:

G 510 42 CFR 484.55 Comprehensive Assessment of Patients

Since these deficiencies limit your capacity to provide adequate care to patients, you must respond within ten calendar (10) days with your plan of correction. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency. An acceptable plan of correction must contain the following elements:

The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;

- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- What correction action(s) will be accomplished for those patients found to have been affectedby the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficientpractice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that thedeficient practice does not recur;
- The monitoring procedure to ensure that the plan of correction is effective and that the specificdeficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e.,what quality assurance program will be put into place
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

If your agency has failed to achieve compliance by the date certain, sanctions including but not limited to fines of up to $10,000.00 per day, may be recommended for imposition to the Centers for Medicare and Medicaid Services (CMS) Regional Office. Informal dispute resolution (IDR) for the cited deficiencies will not delay imposition of any recommended enforcement actions. A change in the seriousness of the noncompliance at the time of the revisit may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

The plan of correction should be directed to:

**Annette Winters, Rapid Response Unit Supervisor**
**Metro 1, Golden Rule Office**
**Licensing and Certification Program**
**Health Regulation Division**
**Minnesota Department of Health**
**85 East Seventh Place, Suite 220**
**P.O. Box 64900**
**Saint Paul, Minnesota 55164-0900**
**Email: annette.m.winters@state.mn.us**
**Mobile: (651) 558-7558**

**Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days of your receipt of this notice may result in imposition of sanctions, decertification and/or a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action. If, upon a revisit within forty-five (45) days of the survey exit date, correction is not ascertained, we will have no recourse except to recommend to the Centers for Medicare and Medicaid Services Chicago Region V Office that sanctions be imposed.**

**HOME HEALTH AIDE TRAINING AND/OR COMPETENCY EVALUATION PROHIBITION**

Federal Law, as specified in 42 CFR 484.80(f)(3), prohibits any home health agency from offering and/or conducting a home health aide training and/or competency evaluation program which, within the previous two years, has been found:

(A) Out of compliance with requirements of 42 CFR 484.80(f)(3);

(B) To permit an individual that does not meet the definition of “home health aide” as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers);

(C) Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State);

(D) Has been assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction;

(E) Has been found to have compliance deficiencies that endanger the health and safety of the HHA’s patients and has had a temporary management appointed to oversee the management of the HHA;

(F) Has had all or part of its Medicare payments suspended; or

(G) Under any Federal or State law within the 2-year period beginning on October 1, 1988--

(1) Has had its participation in the Medicare program terminated;

(2) Has been assessed a penalty of not less than $5,000 for deficiencies in Federal or State standards for HHAs;

(3) Was subject to a suspension of Medicare payments to which it otherwise would have been entitled;

(4) Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA’s patients; or

(5) Was closed or had its residents transferred by the State.

Therefore, your facility is precluded from conducting a home health aide training and/or competency evaluation program for a period of two years beginning April 13, 2023. This does not apply to or affect any previously imposed NATCEP loss.

**INFORMAL DISPUTE RESOLUTION**

In accordance with 42 CFR 488.745, you have one opportunity to dispute condition-level survey findings warranting a sanction through an informal dispute resolution process.  You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

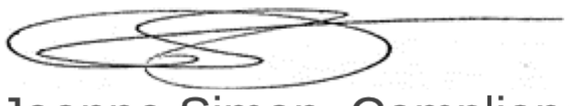
Home Health Agency Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies.

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of sanctions.

If you have any questions on this matter, please do not hesitate to call.

Sincerely,



Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc:  Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

May 4, 2023

Administrator
ADARA HOME HEALTH INC
25 1ST AVENUE NE STE 100
BUFFALO, MN 55313

RE: Event ID: 5F7C5-H1

Dear Administrator:

An partial extended survey was completed at your agency on April 13, 2023 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division noted one or more deficiencies and found that your agency was not in substantial compliance with the participation requirements. The findings from this survey are documented on the electronically delivered form CMS 2567.

At the time of this survey, it was determined that the following Condition(s) of Participation were found not met:

G 536 42 CFR 484.55 Comprehensive Assessment of Patients

Since these deficiencies limit your capacity to provide adequate care to patients, you must respond within ten calendar (10) days with your plan of correction. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency. An acceptable plan of correction must contain the following elements:

The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;

- ·The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- What correction action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e., what quality assurance program will be put into place;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

If your agency has failed to achieve compliance by the date certain, sanctions including but not limited to fines of up to $10,000.00 per day, may be recommended for imposition to the Centers for Medicare and Medicaid Services (CMS) Regional Office. Informal dispute resolution (IDR) for the cited deficiencies will not delay imposition of any recommended enforcement actions. A change in the seriousness of the noncompliance at the time of the revisit may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

The plan of correction should be directed to:

**Annette Winters, Rapid Response Unit Supervisor**
**Metro 1, Golden Rule Office**
**Licensing and Certification Program**
**Health Regulation Division**
**Minnesota Department of Health**
**85 East Seventh Place, Suite 220**
**P.O. Box 64900**
**Saint Paul, Minnesota 55164-0900**
**Email: annette.m.winters@state.mn.us**
**Mobile: (651) 558-7558**

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days of your receipt of this notice may result in imposition of sanctions, decertification and/or a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action. If, upon a revisit within forty-five (45) days of the survey exit date, correction is not ascertained, we

will have no recourse except to recommend to the Centers for Medicare and Medicaid Services Chicago Region V Office that sanctions be imposed.

**HOME HEALTH AIDE TRAINING AND/OR COMPETENCY EVALUATION PROHIBITION**

Federal Law, as specified in 42 CFR **484.80(f)(3)**, prohibits any home health agency from offering and/or conducting a home health aide training and/or competency evaluation program which, within the previous two years, has been found:

(A) Out of compliance with requirements of 42 CFR 484.80(f)(3);

(B) To permit an individual that does not meet the definition of “home health aide” as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers);

(C) Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State);

(D) Has been assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction;

(E) Has been found to have compliance deficiencies that endanger the health and safety of the HHA’s patients and has had a temporary management appointed to oversee the management of the HHA;

(F) Has had all or part of its Medicare payments suspended; or

(G) Under any Federal or State law within the 2-year period beginning on October 1, 1988--

(1) Has had its participation in the Medicare program terminated;
(2) Has been assessed a penalty of not less than $5,000 for deficiencies in Federal or State standards for HHAs;
(3) Was subject to a suspension of Medicare payments to which it otherwise would have been entitled;
(4) Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA’s patients; or

(5) Was closed or had its residents transferred by the State.

Therefore, your facility is precluded from conducting a home health aide training and/or competency evaluation program for a period of two years beginning April 13, 2023. This does not apply to or affect any previously imposed NATCEP loss.

**INFORMAL DISPUTE RESOLUTION**

In accordance with 42 CFR 488.745, you have one opportunity to dispute condition-level survey findings warranting a sanction through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Home Health Agency Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies.

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of sanctions.

If you have any questions on this matter, please do not hesitate to call.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

May 4, 2023

Administrator
ADARA HOME HEALTH INC
25 1ST AVENUE NE STE 100
BUFFALO, MN 55313

Re: Event ID:

Dear Administrator:

A survey of the Home Care Provider named above was completed on April 13, 2023, for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under Minnesota Statutes Sections 144A.43 to 144A.482.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File